

CERTIFICATE OF DEATH

10295

Reg. Dist. No.

10321

M

PLACE OF DEATH

a. COUNTY

GARRETT

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

GARRETT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL ACCIDENT

c. LENGTH OF STAY IN 1b

LIFE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X RURAL ACCIDENT

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

JOHN

First

Middle

Last

WILLIAM FAZENBAKER

4. DATE OF DEATH

Month

Day

Year

SEPT

23

1960

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

MAY 14 1879

9. AGE (In years last birthday)

81 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABOR

10b. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

ACCIDENT, GARRETT Co MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN T. FAZENBAKER

14. MOTHER'S MAIDEN NAME

SUSAN BITTINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

John Henry Fazenbaker, Accident, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

450.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Hypochromic Anemia

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Feb. 25-1, 1956, to Sept 6, 1960, that I last saw the deceased alive on August 6, 1960, and that death occurred at 2:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE

E. J. Baumgartner

M.D.

25 ALDEN ST

ADDRESS (Street, city or town, state)

DATE SIGNED

9/24/60

PHYSICIAN'S NAME (Type)

E. J. BAUMGARTNER

OAKLAND-MD

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9/25/60

22c. NAME OF CEMETERY OR CREMATORY

BETHESDA

22d. LOCATION (City, town, or county)

RURAL BRANTSVILLE GARRETT Co MD

23. FUNERAL DIRECTOR'S SIGNATURE

Don J Newman, Brantville, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE SEP 28 '60

24b. REGISTRAR'S SIGNATURE

Charles S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10901

STATE OF NEW YORK

1881

(M)

(1)

RECEIVED
JAN 10 1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

CERTIFICATE OF DEATH

Reg. Dist. No. 10296

M

090

I

1. PLACE OF DEATH o. COUNTY Garrett County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia COUNTY Preston ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Rest Nursing Home		d. STREET ADDRESS 85X-3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Cora Middle Sanders Last McCabe		4. DATE OF DEATH Month September Day 14 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 8 Days 13	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New East White Haven,	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel E. Sanders		14. MOTHER'S MAIDEN NAME Penna. Mary Bean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Edna Osborne		Address Kingwood, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.9 DUE TO Extensive sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18740			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/29 , 19 58 , to 9/14/60 , 19 , that I last saw the deceased alive on 8/29 , 19 60 , and that death occurred at 9:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 101 Third Street DATE SIGNED ACTUAL SIGNATURE A.E. Mance M.D. PHYSICIAN'S NAME (Type) A.E. Mance, M.D. Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/7/60	
22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Kingwood, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Anna Lane Ligon Williams		24a. REC'D BY REGISTRAR SEP 27 '60	
ADDRESS Kingwood, W. Va.		24b. REGISTRAR'S SIGNATURE Arthur L. Hance	

CERTIFICATE OF DEATH

10812



NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1935"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "08/20/1955"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		OFFICIAL SEAL [Faint text, possibly "Baltimore, Md."]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10316
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10297
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Rest Home		d. STREET ADDRESS 85X-3		
3. NAME OF DECEASED (Type or print) First Middle Last Cora Blanche Ormand		4. DATE OF DEATH Month Day Year Sept. 12, 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1873	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 16	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Pisgah, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Wilmer Collins		14. MOTHER'S MAIDEN NAME Harriett Metheny		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		
INFORMANT Marchall Zweyers, Terra Alta, West Virginia.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Auricular fibrillation DUE TO (c) Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 1 hour Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis. Stasis ulcer of right ankle.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-12-60 A.M. , 19 60 , to 9-12-60 P.M. , 19 60 , that I last saw the deceased alive on 9-12-60 , 19 60 , and that death occurred at 11:50 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9-15-60				
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.				
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M.D.		Oakland, Maryland.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 9/15/60		
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery,		22d. LOCATION (City, town, or county) (State) near Pisgah, West Virginia.		
23. FUNERAL DIRECTOR'S SIGNATURE Terra Alta, West Virginia Md F D License A8305		24a. REC'D BY REGISTRAR DATE SEP 19 '60		
24b. REGISTRAR'S SIGNATURE Arthur L. Evans				

1. The first part of the document is a letterhead containing the name of the organization and the title of the document. This is followed by a series of paragraphs of text, which are separated by line breaks. The text is written in a formal, professional style and appears to be a report or a memorandum. The paragraphs are numbered and contain detailed information about the subject matter. The text is written in a clear, concise manner and is easy to read. The document is well-organized and follows a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The document is a good example of professional writing and is a valuable resource for anyone interested in the subject matter.

2. The second part of the document is a list of references. This list contains a series of entries, each of which is a citation of a source. The entries are written in a standard format and are easy to read. The list is well-organized and follows a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The list is a good example of professional writing and is a valuable resource for anyone interested in the subject matter.

3. The third part of the document is a series of footnotes. These footnotes are written in a standard format and are easy to read. The footnotes are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The footnotes are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

4. The fourth part of the document is a series of appendices. These appendices are written in a standard format and are easy to read. The appendices are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The appendices are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

5. The fifth part of the document is a series of tables. These tables are written in a standard format and are easy to read. The tables are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The tables are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

6. The sixth part of the document is a series of figures. These figures are written in a standard format and are easy to read. The figures are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The figures are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

7. The seventh part of the document is a series of charts. These charts are written in a standard format and are easy to read. The charts are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The charts are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

8. The eighth part of the document is a series of graphs. These graphs are written in a standard format and are easy to read. The graphs are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The graphs are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

9. The ninth part of the document is a series of maps. These maps are written in a standard format and are easy to read. The maps are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The maps are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

10. The tenth part of the document is a series of tables. These tables are written in a standard format and are easy to read. The tables are well-organized and follow a logical structure. The information is presented in a way that is easy to understand and is useful for the reader. The tables are a good example of professional writing and are a valuable resource for anyone interested in the subject matter.

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10298

10317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 37 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppert Nursing Home		e. STREET ADDRESS 10 So. Allegany Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie Annie Barbara Porter		4. DATE OF DEATH Month 9 Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Morantown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Engle		14. MOTHER'S MAIDEN NAME Catherine Bittner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Patients Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Advanced DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1959 , to Sept 16, 1960 , that I last saw the deceased alive on Sept 16, 1960 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 17 Sept 60	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, 77 Oak Street, Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 20 '60	
24b. REGISTRAR'S SIGNATURE William S. Haas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10299											
Item 7 Film 6271 9-26-60 et											
1. PLACE OF DEATH e. COUNTY Garrett MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Alleg.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Deer Park, Md. Minutes						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS 225 Wood St., Extended					
3. NAME OF DECEASED (Type or print) First Alvin Middle Luther Last Roderick						4. DATE OF DEATH Month Sept. Day 18th Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1932		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.a.	
13. FATHER'S NAME Carl L. Roderick						14. MOTHER'S MAIDEN NAME Edna Sollars					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1953-1955						16. SOCIAL SECURITY NO. 212-32-8041					
17. INFORMANT Mrs. Edna Roderick-Westernport, Md						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)											
SHOCK; THORACIC & ABDOMINAL HEMORRHAGE											
825x DUE TO											
CRUSHED CHEST; ruptured SPLEEN, LIVER											
10 Min.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident Rt. 135 & R. 495, Nr. Deer Park, Md.											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:15 p.m. 9-18 1960											
20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway											
20f. (City or town) (County) (State) Rural Deer Park Garr., Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 9-18-60											
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.											
Address (Street, city, town, or county) Oakland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 9/21/60											
22c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cem.											
22d. LOCATION (City, town, or country) (State) Elkgarden W. Va.											
23. FUNERAL DIRECTOR El Boral											
ADDRESS Westernport, Md.											
24a. REC'D BY REGISTRAR DATE SEP 20 '60											
24b. REGISTRAR'S SIGNATURE Arthur L. Krens											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

(M)

70

MEDICAL CERTIFICATION

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10500

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Md.		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md. X			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett Co., Memorial Hosp. Oakland Md.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDDIE RAY STANTON				4. DATE OF DEATH Month Sept. Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1944	
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15		IF UNDER 24 HRS. Hours 15 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Northern High		11. BIRTHPLACE (State or foreign country) Jennings, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Stanton				14. MOTHER'S MAIDEN NAME Mable Hoover			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) none				17. INFORMANT Address Edward Stanton, Accident, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE (ASPHYXIATION) DUE TO GUNSHOT WOUND, LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) OWN GUN DISCHARGED, MISSILE GOING THROUGH LUNG.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ACCIDENT, GARRETT, MD.			
20c. TIME OF INJURY Month, Day, Year Hour 10:30 p.m. Sept. 1 19 60				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) ACCIDENT, GARRETT, MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oakland, Md. 9/3/60 DATE SIGNED EXAMINER'S SIGNATURE JAMES H. FEASTER, Jr. M.D. EXAMINER'S NAME (Type) Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/5/60 22c. NAME OF CEMETERY OR CREMATORY Bittinger 22d. LOCATION (City, town, or country) (State) Bittinger, Garrett Co., Md. 23. FUNERAL DIRECTOR Don Newman ADDRESS Grantsville, Md. 24a. REC'D BY REGISTRAR SEP 9 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

RECEIVED
FBI NEW YORK



RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

11414

1. PLACE OF DEATH a. COUNTY <i>Sancti Spiritus</i> <i>Sancti Spiritus</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Friendsville</i> b. COUNTY <i>Barrett Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendsville MD</i>		c. LENGTH OF STAY IN 1b <i>all of life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Eda Belle Thomas</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30, 1876-84</i>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSE, WIFE</i>	
11. BIRTHPLACE (State or foreign country) <i>Friendsville MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Eliga Thomas Friendsville</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Ingeel Friendsville</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Barbara Ingeel Friendsville</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy - "Stroke"</i> DUE TO <i>334X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO <i>10 yrs.</i> (c) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>36 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Arthritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injuries</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 2, 1960</i> to <i>Sept 28, 1960</i> , that I last saw the deceased alive on <i>Sept 27, 1960</i> , and that death occurred at <i>4:04</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edwin M. Price MD</i>		ADDRESS (Street, city or town, state) <i>612 Lagan Place Confluence Pa</i>	
PHYSICIAN'S NAME (Type) <i>Edwin M. Price, M.D. Confluence, Pa.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Sancti Spiritus</i>		22d. LOCATION (City, town, or county) (State) <i>Friendsville MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edmund Branden</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>OCT 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Knaus</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		10. SIGNATURE OF REGISTRAR <i>John Doe</i>	
11. DATE OF DEATH <i>Jan 20 1945</i>		12. TIME OF DEATH <i>10:00 AM</i>	
13. PLACE OF DEATH <i>Home</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEAREST RELATIVE <i>John Doe</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10319

CERTIFICATE OF DEATH

10301

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS THIRD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFA Middle JEANETTE Last THRASHER		4. DATE OF DEATH Month SEPTEMBER Day 16 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 23, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shop keeper		10b. KIND OF BUSINESS OR INDUSTRY GIFT SHOP	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUGHRIDGE, GEORGE		14. MOTHER'S MAIDEN NAME STEMPLE, MARTHA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-34-1239A	
17. INFORMANT MRS. GROVER STEMPLE, OAKLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 Sept. 16 1960, that (I) (we) last saw the deceased alive on Sept. 15 1960, and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 16 Sept 60	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		22d. ADDRESS OAKLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/1960	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE H. E. Leighton		ADDRESS Oakland, Md.	
25a. REC'D BY REGISTRAR SEP 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



ACR-105-105

105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10320

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10302

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 78 OAK STREET	
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last TROWBRIDGE		4. DATE OF DEATH SEPTEMBER 30 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM FRANKLIN STEWARD		14. MOTHER'S MAIDEN NAME HELEN MELISSA LERAW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-01-5558	
17. INFORMANT BOMER TROWBRIDGE		Address 78 OAK ST., OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cerebrovascular Dis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 years 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 10:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance M.D.		22b. DATE SIGNED 10/20/60	
22c. PHYSICIAN'S NAME (Type) DR. ANDREW E. MANCE M.D.		22d. ADDRESS OAKLAND, MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 10/3/60	
23c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		23d. LOCATION (City, town, or county) (State) Elk Garden, Mineral Co. W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Amy M. Sharpless		25a. REC'D BY REGISTRAR Blaine, W. Va.	
25b. REGISTRAR'S SIGNATURE Colleen S. Kraus		DATE OCT 5 '60	

101

10620
CERTIFICATE OF DEATH

Blank form with faint horizontal lines and vertical columns for data entry.

1

CORRECTION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10303

FOR STATE HEALTH DEPT. M

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crellin c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crellin d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Abraham First Rudolph Middle Wilson Last			4. DATE OF DEATH 9 Month 5 Day 19 Year 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1882	9. AGE (In years birthday) 77 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY County Rds. Dept.		11. BIRTHPLACE (State or foreign country) Oakland, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen Wilson			14. MOTHER'S MAIDEN NAME Virginia Fulmer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Samuel Wilson Address Crellin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO Myocardial insufficiency (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH Sudden Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. James H. Feaster, Jr., M.D.		DATE SIGNED 9-7-60			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		Address (Street, city, town, or county) Oakland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9/8/1960	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or country) (State) Oakland, Maryland				
23. FUNERAL DIRECTOR Gerald N. Minnich		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR SEP 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

